

## Action for Children response to Lord Laming – 5 December 2008

Dear Lord Laming,

Action for Children would like to thank you for providing us with the opportunity to share our thoughts on the best way to deliver effective safeguarding arrangements for children. We were all very shocked and sad to hear about the tragic death of Baby P, and are keen to work with other agencies to understand the issues and learn from the reviews that have been commissioned. As a child care organisation, we recognise the complex, challenging and successful work that goes on day in day out to keep children safe in difficult circumstances, and we are proud of the role that our staff play in this in many communities across the UK.

Action for Children is committed to helping the most vulnerable children and young people in the UK break through injustice, deprivation and inequality, so they can achieve their full potential. We believe all children and young people have unique potential and that they should have the support and opportunities they need to reach it. Action for Children helps nearly 170,000 children, young people and their families through nearly 450 projects across the UK. We also promote social justice by lobbying and campaigning for change. Today, Action for Children is the leading UK provider of family and community centres, children's services in rural areas, services for disabled children and their families, and services for young people leaving care.

We are keen to contribute our views to this review and see our response as part of an on-going dialogue with the government and key stakeholders about how we can all work together to improve outcomes for children and young people.

### Key messages:

- Action for Children welcomes the intention to review best practice, much of which has been developing locally throughout the country. We firmly believe that the best way forward is to identify and build on the strengths already in our system, rather than a rush to introduce further changes in child care legislation.
- We believe that this review needs to take time. Action for Children would like to call for a more sustainable process: we believe the best way to deliver effective safeguarding arrangements is to develop a long term understanding of what works - rather than undertaking a series of short term reviews focused on what has gone wrong.
- We are concerned that the current media furore may increase the pressure to look for quick fixes. There needs to be a move away from the pendulum swing between investment in early intervention and investment in acute services for those most in need of protection and support. We must stop offering family support on the one hand and child protection on the other. Investment is needed in both as these services represent a continuum. We need a flexible system able to offer a coherent response which is based on the best outcomes for that individual child.



- Agencies are still not working together effectively to manage risk. What is needed is a shared culture across agency boundaries. Recent changes in guidance and legislation, especially the moves to strengthen Children's Trusts, are steps in the right direction but have not yet achieved the necessary cultural change on the ground.
- Systems on their own do not protect children – people do that. Children need a system that promotes and supports effective decision making. To achieve this will require investment in the training, supervision and management of those staff who work to protect the most vulnerable children and young people.

**Q1: What good practice has been successfully achieved in safeguarding children since the publication of the Victoria Climbié Inquiry Report?**

**Investment in prevention and early intervention**

The investment in prevention and early intervention, especially through the provision of early years services, has allowed agencies to work with a broad range of families and identify where more targeted interventions are needed. Sure Start Children's Centres (SSCCs) have, by delivering an integrated multi-agency service, provided far greater opportunities to work with a broad range of families and children.

Action for Children has commissioned a new, independent national study looking at the delivery of targeted family support services through Action for Children run early years services. Initial findings include:

- The measurement of an individual child level outcome needs to allow for the concept of *added value*, given the complex needs of many families in receipt of targeted services. A genuinely preventive approach seeks - at every point - to prevent "something worse" happening, whatever that may be. This is important in understanding both the importance of early intervention and of sustained service access.
- Intensive family support based on sustained professional relationships can be effective in some cases of neglect.
- It is a mistake to view the "revolving door" as an indicator of a service deficit. On the contrary the "open door" approach sustained across the projects was likely to maximise positive outcomes, given that it facilitated early access at whatever stage of the problem.
- Intensive support can make a positive difference to the lives of children and their families in even the most challenging circumstances.
- Targeted support is not seen as stigmatising by parents and young people, who welcome a *personalised* approach to their problems in order to produce *personalised* outcomes

The full research is due to be published early in 2009. As a follow on, we are developing a longitudinal study looking at responses to neglect within Action for Children early years services. We already understand that targeted interventions are effective in some cases of neglect, but want to build on this knowledge to understand what interventions are effective in which circumstances. We also believe it is important to take a longer term view, which is why we have commissioned this four year study.

**A broader range of safeguarding issues are now being picked up**

The move from a narrow focus on 'child protection' to 'safeguarding' has enabled a broader range of issues to receive attention. For example, the question of safeguarding teenagers has grown in importance. The success of the Home Loan Safety Equipment Scheme provides another example.

In addition, the new Child Death Review Panels have provided a useful source of good quality information. This has informed local decision making on a range of issues, such as road traffic planning in order to prevent the deaths of young people at traffic crash "hotspots".

**Move towards outcomes based evaluations**

Moves in voluntary and statutory sectors towards greater results based accountability following the work of Mark Friedman and the new Centre for Excellence and Outcomes in Children and Young People's Services (C4EO). This means that local authorities and partners now have the prospect of becoming

less dependent on process-driven performance indicators as the mechanism for measuring success. The C4EO is active in reviewing and understanding studies of services in local authorities, building up our knowledge of what works in improving outcomes for children and young people. It is also to be hoped that this knowledge will inform commissioning practice.

### **Improved inspection arrangements**

In recent years OFSTED have been active in talking to local authorities about the quality of their Serious Case Review (SCR) reports as well as collating recommendations. Every review is now rated and evaluated with feedback provided to the local authority. We would like this process to go further in future, in particular with other key agencies also receiving copies of OFSTED reports.

### **Government action on specific safeguarding issues**

The government has produced useful multi-agency guidance on a range of difficult safeguarding issues including child trafficking and spirit possession.

### **Good practice in individual local authority areas**

The voluntary and community sector plays a vital part in meeting the needs of children and families, with a unique ability to reach into and work with vulnerable and marginalised groups. From our experience of working with partners to provide local services to vulnerable children and families, we are aware of excellent practice in some areas:

- Talking to our local service providers, we know that in some local authority areas there have been real improvements in inter-agency working since the publication of the Victoria Climbié report.
- Again, in some areas Local Safeguarding Children Boards (LSCBs) have been successful in applying a broader approach which links early intervention processes to effective safeguarding. In these areas LSCBs have been successful in bringing agencies together.
- Engagement with third sector and faith organisations by some local authorities.

In all of these we are aware of local examples of good practice but know that the national picture is patchy, with a high degree of confusion and inconsistent implementation. What is needed now is effort to learn from these areas of best practice. We would like to see reviews and changes to the system built upon an understanding of what works rather than what's failing.

***Q2: What are the key barriers, including in the legal process, that may impede efficient and effective work with children and families that may be preventing good safeguarding practice from becoming standard practice everywhere, for example in deciding whether an application should be made to take a child into care? Is the right balance being struck between the correct application of processes and the needs of the child?***

### **Lack of a knowledge base about what works**

We need a safeguarding system built upon a sound evidence base of what works in keeping children safe, and in which situations. The system must be based on an understanding of what interventions might likely prevent further deterioration and which situations cannot be prevented by interventions of professionals. We need to be wary of simplistic messages and a culture of short term reviews which will not give us the depth of information we require.

Action for Children is also concerned about the high degree of churn in structures and systems that can lead to confusion and damage recruitment and retention of key staff, while also taking the focus away from children and young people. Too often systems have not been fully implemented before they are reviewed. Our recent report, *As long as it takes: a new politics for children*, showed that during the lifetime of someone turning 21 this year, there will have been over 400 different major announcements affecting children and young people – with each new initiative lasting, on average, a little over two years.

### **Barriers to effective decision making processes**

The barriers to effective working are not predominantly about the intentions of policy, legislation or performance measures – but about how these resources are interpreted and acted upon by practitioners

and managers. These decisions will be affected by competing priorities and the resources available, as well as the incentives inherent in the local performance framework.

The government's performance regime can place statutory agencies on the defensive and militate against acknowledging weaknesses. It can also reduce trust in front line social workers and professionals, with concern now being expressed about decisions being taken by senior staff who are removed from direct contact with a child.

There are perverse incentives inherent in some performance measures, such as OFSTED providing positive inspection ratings on the basis of authorities reducing numbers of children in care or subject to formal child protection planning. We are concerned at the pressures such inspection ratings put upon front-line decision making. The focus should always be on getting the right children in care and the right children supported to live with their families.

The abolition of the Child Protection Register in England and Wales appears to have been an abolition in name only. Local authorities are still monitored in exactly the same ways around the child protection conference and many professionals still talk about the child protection register. We wonder whether there should be a return to the robust multi-agency decision-making around the register and needs, whilst at the same time not losing some of the aspiration to extend this level of multi-agency collaboration to lower levels of need.

The government will need to focus on actions that are aimed at supporting effective local decision making. This will should include a look at how decision making as reviewed within local authorities. The current lack of clarity about agency roles and responsibilities can leave vital decisions resting with individual social workers and team managers – when what is needed is a more effective shared decision making process.

### **Demoralisation of the children's workforce**

We will all need to identify the positives to avoid demoralisation of the children's workforce. Action for Children would like to see more government action to boost the status of the profession, as has been done for the teaching profession. Specifically, newly qualified social workers need support in their first two years post qualification.

### **Too broad a focus on safeguarding?**

We wonder whether the arrangements brought in under the Children Act 2004 have created a change of focus away from the small group of children who will need protection. Does the new broader safeguarding agenda mean that there is insufficient attention paid to those children at, or likely to be at, risk of significant harm? Can LSCBs adequately address the needs for safeguarding at so many different levels of need or is this task too large to ensure a safe child protection service at the acute end is not diluted?

### **Thresholds**

Our front line practitioners continue to raise concerns about where the thresholds are set, and variations in this, as well as questioning whether decisions are linked to the resources available rather than to need. A particular concern is that a gap in provision is emerging between early intervention and very high level interventions (i.e. in the middle of the tiers of need). We need to better understand the link between thresholds to support and thresholds to protection.

Much of this evidence is anecdotal. Research is needed to see if thresholds have changed, as well as to look at the reasons behind the variations between local areas.

### **Budgets**

The recent review of LSCBs highlighted the continued problems with locally negotiated budgets and inconsistent contributions from different agencies, with health presenting a particular problem. We believe that the lack of pooled budgets means that LSCBs can remain a virtual concept and not a real one, becoming emasculated by Children's Trust arrangements with their focus on all children. We

welcome the proposals to strengthen the role of Children's Trusts and Children and Young People's Plans, and understand that the current stock take of LSCBs will also consider the relationship between Children's Trusts and LSCBs. We hope that this work provides an opportunity to introduce strengthened proposals that ensure more consistent contributions across agencies.

### **Possible disincentives to initiating court proceedings**

Could it be that the adversarial nature of court proceedings in children's cases can be a deterrent, meaning that workers feel unable to take action without amassing a level of evidence which will stand up to all forms of scrutiny? This lies uneasily with the need to act without delay to secure a child's best interests. This situation may be exacerbated by the relatively low status afforded to social care professionals in court and their experience of hostile cross examination in the courtroom. We also wonder how adequately social workers are prepared for court work and whether they are equipped with the necessary skills.

We also wonder whether the Public Law Outline, with its emphasis on informal dispute resolution, could lead to delays in the child protection system. Anecdotal evidence shows managers encouraging staff to run through what can be an inflexible menu of interventions in the context of individual children before they can move onto considering court proceedings. This may undermine professional judgements, especially in those cases which are hard to call.

The increased financial responsibilities on local authorities for paying so much more for care proceedings are likely to have discouraged their use further.

### **Separation of children's and adults' agendas**

This separation can result in barriers to accessing resources. Parents may not get access to mental health support, and this will have implications for their children. In addition to this there are also issues regarding risk assessments focusing on adult mental health needs and not on the needs of the children involved with these adults, and reluctance on some occasions to plan and share information effectively

### **Working with men**

Too often significant male figures (be they fathers, male carers, extended family members, or new partners) remain invisible within safeguarding processes. Information is not sought which may prove vital in terms of identifying both protective factors and risk.

### ***Q3: What specific actions should be taken by Government and national and local agencies to overcome these barriers and accelerate systematic improvements in safeguarding practice across the country?***

### **Supporting practitioners and managers**

Whatever legal and policy framework is in place, front line staff will always be required to make decisions in complex situations on critical questions relating to children's needs and possible risk of harm. They must have not only good quality training but also high quality supervision and management. It is essential to ensure that time for casework reflection is prioritised in fortnightly or weekly supervision sessions which we fear have too often become places where the social worker is held to account for completion of activities and processes rather than consideration of outcomes being obtained for children. We also wonder if sufficient time for reflecting on the child's experience is built into Child Protection Case Conferences.

To ensure the quality of supervision and management it is essential that first line managers have the right skills, experience and training to support and manage front line staff. They also need access to expert advice and consultation.

One option might be for the government to fund local authorities to sponsor regional seminars to enable the sharing of good practice and to ensure that the focal point of team managers and social workers is their professional role improving outcomes for children.

## **Thresholds**

As we stated under question 2, there needs to be research into thresholds based on what is happening on the ground. Much of the evidence at the moment is anecdotal and we need to get underneath this to ascertain if thresholds really have got higher, and if they have what the reasons for this are.

## **Pooled budgets**

We would like to see improved budgeting arrangements for LSCBs to ensure there is a mechanism to determine consistent levels of financial contribution across key agencies.

## **More sensitive performance measures**

We would like to see an end to the use of judgements about numbers in care or at risk as a measure of a good service or otherwise. Instead we would like to see more meaningful performance measures adopted. These should be developed from outcomes-based measures for effective intervention in family support and child protection. Such measures would require all services to be clear about goals for services and individual service users. It would also require all services to measure performance against achievement of those goals and to use both numerical and qualitative information from staff and service users, most especially children themselves.

Linked to this, we are concerned to ensure that IT systems are introduced to assist and not provide a cumbersome barrier to effective recording or seeing service users.

## **Guidance for working with men**

We would like to see strengthened guidance for working with men (fathers, male carers, male relatives and partners) in safeguarding cases.

## **Strengthen the Serious Case Review process**

Action for Children would like to see:

- Increased independence of authors in SCRs, and the accreditation of report authors. We understand that the DCSF is introducing a list but there needs to be an accompanying approval process.
- Greater independence of SCRs, especially when it comes to the selection of chairs. The Haringey report has been criticised for being overly defensive, and the SCR was chaired by the Director of Children's Services. We believe independence is necessary to avoid this criticism.
- Consider revising the SCR criteria so that greater weight is placed on understanding context: why did someone do, or not do, something or why did they do something badly? This is important to ensure that process remains one concentrated on learning and not on blaming front-line practitioners. It is very important that we do not return to the experience of the 1980s and 90s when case reviews were often constituted as inquiries seeking to hold practitioners and managers to account and when reports contained a dizzying number of recommendations which were often lost in implementation.
- Commission training in how to write single agency review reports. Action for Children has one of the small number of courses which has been used to good effect both internally and with external multi-agency audiences.

## **Safeguarding in Sure Start Children's Centres**

As a major provider of Sure Start Children's Centres (SSCCs) our staff members have highlighted some concerns about the multi-agency safeguarding arrangements that currently operate within some SSCCs. For example, we have concerns that within some SSCCs each agency has a separate file for each child. We believe that this is a very risky practice and, in fact, it has already been identified in some serious case reviews. In our response to the consultation looking at putting SSCCs onto a statutory basis we made the following suggestions:

- We want to see clear lines of accountability for safeguarding within SSCCs developed for all staff and volunteers.
- When setting up a SSCC it must be made clear which agency's policies and procedures are to be followed. There must be clarity about both management and professional advice to workers, and the role of supervision.

- There must be agreement on the expectations for staff regarding safeguarding training and competency and this must be regularly monitored.
- Each SSCC should have a designated lead on safeguarding (similar to that in schools)
- The role of SSCCs in safeguarding should be recognised both by the SSCC itself and in the wider safeguarding network.

### **Services for victims**

Running in tandem with the suggestions outlined above, Action for Children would like to see greater consistency in the provision of services for victims of abuse and neglect. Specifically we would like to see investment in therapeutic interventions for victims of abuse linked to achievement of specific and identifiable life changing goals. Action for Children runs a number of therapeutic services for child sex abuse survivors. These services are oversubscribed and have long waiting lists. If the government is serious about protecting children from harm, then it needs to invest in interventions for children and young people who have been neglected and abused. Without such interventions the danger of poor outcomes and negative long term impact is increased. Currently, Action for Children is undertaking a DCSF funded evaluation of our Child Sexual Abuse services. Interim findings are due to be reported on next year. We are very keen to share our learning as broadly as possible.

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